UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

HYDROXYPROGESTERONE CAPROATE (17-p)

Patient name:_____Medicaid or SS#_____
Physician Name:_____Contact person:_____
Phone#:_____Ext. and opt._____Fax#_____
Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO: 801-536-0477

CRITERIA:

- Approved for the prevention of preterm labor for patients with prior history of preterm delivery.
- Must be prescribed by OBGYN.
- Therapy initiated between weeks 16-23 of gestation.
- Pharmacy provider must submit evidence of compliance with USHP 797 standards for sterile preparation of the injection.

AUTHORIZATION:

For duration of the pregnancy

RE-AUTHORIZATION:

Same as initial

01/28/2009